



Policy Memo	
KDHE-DHCF POLICY NO: 2017-03-01	From: Jeanine Schieferecke, Senior Manager
Date: March 16, 2017	KEESM Reference: 8200.4, 8272 & subsections KFMAM Reference: N/A
RE: Living Arrangement Changes including HCBS Termination – Special Project	Program(s): All Medical Assistance Programs

This memo replaces KDHE Policy memo 2016-12-03 titled ‘HCBS Termination – Special Project’. This revised memo reiterates previous instructions regarding prospectively ending Home and Community Based Services (HCBS) coverage based upon a special project approved by KDADS and KDHE. It also includes new and clarified policy regarding the termination date of HCBS that is in place until further notice. In addition, the memo provides updated processing instructions for living arrangement changes. These policies and processes are effective upon receipt.

1) POLICY-SPECIAL HCBS PROJECT

As indicated in Policy Memo 2016-12-03, KDADS has identified individuals who are currently receiving benefits as HCBS recipients in KEES/MMIS who are no longer eligible for such services. The individuals have been determined ineligible for HCBS services for a variety of reasons, including non-recipient of approved services for a specified period of time or failure to meet HCBS screening criteria at the last annual review. Leadership staff at both KDADS and KDHE have agreed this must be addressed immediately. Because a large number of individuals have been identified over all HCBS waivers, special processes were implemented for this one-time clean up.

Cases impacted by the project are identified on a series of reports issued by KDADS. KDADS staff are responsible for ensuring all recipients listed on the report are no longer eligible for the waiver.

The following policies were in effect for this one-time project:

A) ES-3161:

Ordinarily, the MCO responsible for HCBS delivery is required to submit an ES-3161 to the KanCare Clearinghouse when a functional HCBS termination is necessary. This requirement is waived for persons appearing on this report. If an ES- 3161 was previously

submitted for these individuals, a task may exist on the case. All existing tasks associated with 3161s shall be reconciled as action is taken on this report. These tasks may appear as Incoming Document tasks or LTC Communication tasks.

B) HCBS Termination Date:

For cases appearing on the report that were processed prior to the receipt of this memo, the HCBS Level of Care (LOC) was terminated effective the end of the last paid benefit month (see MMIS monthly in the KEES dispatch for dates). Unless an exception is noted, no retroactive LOC terminations were made for people identified as part of this project. Note that timely and adequate notice is still required for all actions impacting eligibility.

2) NEW POLICY: ES-3161

The exception noted above continues to be in place for cases appearing on special reports. However, the new policies are applicable to changes received via the ES-3161 as well as those on a report.

Note: The ES is still responsible for sending an ES-3161 for all HCBS determinations once the ES has processed the action.

It is also important to note that the ES is responsible for reviewing the case to determine if subsequent ES-3161's have been received that may suggest an alternative action. In these cases, contact with the waiver manager may be necessary to clarify next steps.

3) NEW POLICY: EFFECTIVE DATE OF LOC TERMINATION

A) Background

Currently, when the appropriate HCBS entity determines an individual is no longer eligible for services (e.g. functional cessation, non-payment of liability, etc.), the eligibility worker is responsible for reacting to this information. Eligibility is adjusted and Level of Care information is also updated to signify the change. This is done by entering the end date of the HCBS care on the KEES LTC Data Details page. The updated information is then sent to the MMIS, where the information is used to terminate LTC coverage. In many cases, this can result in an adjustment to the capitation payment made to the KanCare MCO's. The end date of the HCBS care is determined from the LTC Date Details.

For cases processed based on the original Policy Memo 2016-12-03 (and prior to receipt of this memo), an Adjusted HCBS End Date was created to prevent extreme retroactive adjustments of KanCare rates. In these cases the Adjusted HCBS End Date was the last day of the last paid benefit month (see MMIS monthly in the KEES dispatch for dates).

This memo implements a new policy for establishing an Adjusted HCBS End Date. With receipt of this memo, the effective date policy changed and a new 3-month retroactive termination limit, as described in item A below, is implemented. This shall remain in effect

for all HCBS terminations until further notification. This policy is applicable to any HCBS case where the HCBS entity is terminating services.

B) Retroactive Effective Dates –Adjusted HCBS End Date

Policy is implemented to establish a new Adjusted HCBS End Date that recognizes a 3 month retroactive time period for processing an HCBS Living arrangement change. Based on the date the eligibility worker is making the HCBS change, the HCBS termination date cannot exceed 3 months from the date of action. If the actual HCBS termination date is within the last 3 months, the actual termination date is used. If the actual termination date is earlier than the last 3 months, the adjusted termination date is the last day of the last paid benefit month. For cases moving to a Medically Needy program, this does not apply and an alternate Adjusted HCBS End date is established according to item (4) below. Timely and adequate notice is required.

The need to use an Adjusted HCBS End Date is based on the date the eligibility worker is processing the case. So, if the case is processed on March 10 and the HCBS end date (per the HCBS entity) is prior to December 1, an Adjusted End Date is needed. If the case is processed within the time period – 02/29 for example, the actual HCBS end date is used on the LTC Data Details screen. Note that timely and adequate notice is still required for all actions impacting eligibility (see item 10 below regarding Notice requirements).

Example 1: SSI recipient Jane Doe appears on the report as a FE (Frail Elderly) client who last received services 11/14/16. The effective date of LOC termination is based on the date action is taken. If action is taken on 02/23/17 the three month time frame is November 1 – January 31 (based on a start date of February 1 and the fact the case is being processed in February 2017). Since services ended within the three month time frame, the LOC is ended 11/14/16. Note that Medicaid eligibility would still be in effect since she is an SSI recipient.

However, if action is taken on March 10, the situation is different. The case would then be processed outside of the three month period and the LOC effective date is based on the month of processing. The LOC will terminate effective 03/31/17.

Example 2: HCBS client John Doe has Social Security of \$1,000/mo. He appears on the report as a PD (Physically Disabled) client who last received services on August 10. The case is processed for HCBS termination on March 1. John only wants coverage under an MSP program following HCBS termination. The LOC end date is 03/31/17. Medicaid eligibility remains in effective through March, but must be redetermined effective 04/01/17. His QMB remains in effect effective 04/01/17.

1. EXCEPTIONS:

Exceptions to the retro LTC process continue to apply. The effective date of change continues to be used for deceased recipients or persons changing from one LTC living arrangement to another LTC living arrangement (NF entrance, moving to PACE, MFP, etc.). Regular rules apply to these populations.

2. CHANGE IN PROGRESS:

The new policy is effect for any change that has not been finalized. This includes changes that have been initially processed by Maximus but have not been fully authorized by the State. These cases must be reprocessed according to the new rules.

3. MMIS IMPACT:

HPE staff have been instructed to limit processing of any retroactive HCBS termination adjustment to a maximum of three months. Exceptions exist for changes involving a date of death or a change to another LTC arrangement. These adjustment requests will be targeted and sent to KDHE for processing instructions. It is expected that most of these cases will require eligibility adjustments in order to ensure the cases has been correctly processed according to the new policy.

4) MEDICALLY NEEDED FOLLOWING LTC

This memo clarifies policy for establishing ongoing Medicaid coverage for an individual leaving Long Term Care, specifically regarding Medically Needed coverage. This memo also provides criteria for establishing an Adjusted HCBS End Date when the person will transition to a Medically Needed program.

Note: The policies stated in this section apply to all types of LTC situations – HCBS, institutional, PACE and MFP.

When individuals leave an LTC living arrangement, coverage may be established using Independent Living rules. In some cases, this may involve establishing a Medically Needed spenddown. Not all individuals leaving Long Term Care are automatically provided a spenddown. Criteria has been established to determine if an ongoing Medically Needed case is appropriate when leaving LTC. If the consumer does not meet item (a) or (b) below, a Medically Needed case is not immediately established. See item 4(e) below for cases involving a spouse.

- a. Situations where a spenddown is always established: Unless the individual does not meet eligibility requirements for the Medically needed program, a spenddown shall always be established in the following situations:
 - i. The Consumer requested a spenddown before the LTC change is processed
 - ii. Consumer is leaving a Mental Health facility or State Psychiatric Hospital
 - iii. Countable income is less than \$600/mo.

- iv. The consumer is going home to live with a spouse who has an open spenddown, the consumer is added to that spenddown
- b. If the consumer does not meet the above criteria, an estimate of the consumer's remaining spenddown amount will be calculated off system. This is done using income as well as known/anticipated expenses. The Spenddown Estimating tool will facilitate this determination. The tool has been added to the KEES Repository. The results of the estimate are evaluated and the results used to determine if a new spenddown is established:
 - i. For persons who have QMB, a Medigap policy or other health insurance: If the remaining spenddown is less than \$300 then a spenddown is established.
 - ii. For persons without QMB, a Medigap policy or other health insurance: If the remaining spenddown is less than \$1500 then a spenddown is established.
- c. If a spenddown is not established, the consumer may later request a spenddown. If the request is made later than the last day of the month following the month of action, a new spenddown base period is applicable. If the request comes in after this date, a new application may be required (depending if there is an open program, such as QMB) and any new base period is based on the date of the application.
- d. If Due and Owing or non-covered bills that have not been fully applied, the bills are used to determine the estimated remaining spenddown amount. However, if a spenddown is established, these bills will be end dated the last day of the month HCBS is ended on the LTC Data Details page. Verification of the current due and owing amount as of the first day of the spenddown base period must then be requested before making any continuing allowances.
- e. If the consumer has a spouse who is not receiving LTC or SSI Medicaid, the spousal income, resources and expenses will also be counted in the determination of the spenddown. The following apply:
 - i. Unless a request for coverage for the Community Spouse has been received, ongoing coverage can only be approved for the LTC spouse – the Community spouse would be considered a FRI. If it appears the Community spouse may be eligible for coverage, staff are encouraged to make a phone call to obtain information necessary for the ongoing determination.
 - ii. If the community spouse already has a spenddown base period, the LTC spouse will be added to that spenddown—a separate spenddown would not be set up for the LTC spouse.
 - iii. When estimating the spenddown according to item B, any information from the spousal determination can be used to complete that estimate, unless there is an indication this information may no longer be correct. Keep in mind that in most cases, spousal assets will result in ineligibility. Verification of spousal resources are not needed. If the LTC spouse is no longer eligible, the end date for the LTC is based on Policy in Item 2 (B) above.

- iv. MSP coverage may be established for the LTC spouse if income and resource information is available for the Community Spouse. If timely verification of the couple's income and resources is in the file or otherwise available, MSP coverage is established. Current rules apply for determining if verification is timely (e.g. 3 months for liquid resources, 12 months for non-exempt personal and real property). If timely verification is not available, but spousal information known to the agency indicates ongoing eligibility, MSP is provided but the review period is shortened to the next available cycle. Note that only the LTC spouse is eligible unless a request for coverage has been made by the Community Spouse.
- v. For all other cases where the Community Spouse has not requested coverage, it is not necessary to obtain verification of the Community Spouse expenses prior to completing an estimated Remaining Spenddown. Information known to the agency can be used to determine the estimate. If the spenddown is estimated to be \$600 or less, verification of the spousal income and assets will be necessary before authorizing coverage. If timely verification is not available, it must be requested.
- vi. If the spenddown estimate is greater than \$600, no the client is considered unlikely to meet spenddown and the client must request ongoing Medically Needy coverage. Unless the LTC spouse is eligible for MSP, the case is discontinued. The notice shall inform the couple they may apply for Medically Needy coverage.

5) MEDICALLY NEEDED BASE PERIODS FOLLOWING LTC

When a consumer has left LTC and it is determined that a new spenddown will be established (see item B above), the base period always begins the month following the month LTC actually ends. For example, HCBS services ended on Feb 5, the new spenddown base begins in March. This is true regardless of any Adjusted HCBS End Date that may be necessary.

Regular Medicaid coverage will continue beyond the month of the LTC change until timely notice of the change can be given. However, this does not alter the spenddown base period. Unless action to terminate the LTC coverage is taken immediately, a portion of the spenddown base may overlap with the full Medicaid months. If this occurs, full Medicaid coverage is still in force for those months, but any remaining months in the spenddown period must be met. For example, HCBS services ended on February 5 but action isn't taken until April 25. The new base period begins March 1 and ends in August. However, full Medicaid is provided for March, April and May. The spenddown status will be effective June 1. The MMIS will display eligibility accordingly – with Medicaid in place for March-May and Medically Needy in place from June – August.

For situations where action has been significantly delayed, the base period is established as long as there are still months in the correct base period that have not been paid. This is true even if some of the months of the base period already exist as full Medicaid in the MMIS. For these cases, where the original base has already expired, any new base periods are established based

on the correct original base. For example, in the case above, if action is taken to initially react to the LTC closure in October, the original base of March – August is still applicable even though it has passed. It would not be established in KEES. However, the subsequent base of September – February would be established in KEES.

Cases where the individual has received full Medicaid in error are listed on the overpayment spreadsheet.

6) ADJUSTED HCBS END DATE FOR MEDICALLY NEEDY CASES

When establishing a new Medically Needy spenddown following an HCBS termination, special provisions apply that incorporate both the special three month special rule and the Medically Needy base period rules. KEES processing require the Medically Needy base period be consistent with the end date placed on the LTC Data Details page.

In these cases, an Adjusted HCBS End Date is set if the actual end date of HCBS services is more than 3 months prior to the date the case is processed. If so, the Adjusted HCBS End Date is consistent with the date of the new Medically Needy base period. If the case is processed beyond the 3 month period, the Adjusted HCBS End Date is effective the last day of the current base period.

In other words, the spenddown base is determined and then the Adjusted HCBS end date is determined. In most cases, this will be consistent with the date the services actually ended, but may be adjusted forward to always align with the Medically Needy base period.

In rare instances, the Adjusted HCBS End Date may be set to end 4 months in the past. If the current come up month in KEES prevents terminating the LOC on the date the case is processed, the Adjusted HCBS End Date can be one month earlier. See Example 5.

Example 3: Client left HCBS on 12/31/16. It is determined a spenddown should be established. Based on the date of the LTC end date, base period of 01/17 through 06/17 is applicable. Processing the case on 03/02/17. The HCBS end date is within the applicable period of three months prior to the date of processing, so the LOC end date is aligned with the date of the new base. In this case, it is the actual date of HCBS termination. The LOC end date entered on LTC data details is 12/31/16. Bills from Dec. through March will be paid, but any bills received for April and May will be applied to the full spenddown.

Example 4: Client left HCBS in 08/2016 and the base period should have been 09/16/ through 02/17. Processing the case on 03/02/17. Consumer received full Medicaid coverage through 03/17 with no base period. Since the actual date of the HCBS termination is more than three months in the past, the Adjusted HCBS End Date applies and is set consistent with the new base period that is within three months of the current date. Since the new base begins in March, the Adjusted HCBS End Date is 02/28/17.

The new rules will apply to cases in progress, including those in the State queue. Action initiated will be reprocessed using the new rules.

Example 5: An ES-3161 was received showing HCBS ended 5/31/2016. In November a Maximus worker processed the HCBS closure by updating LTC Data page for the month of May and running EDBC for May. It was sent to the State for processing at that time, but remains pending. Since a spenddown base was not created and EDBC not ran for the following months, the consumer has been receiving full Medicaid because of this. On March 6th an ES picks up the case and realizes a spenddown should have been created for 6/16 through 11/16. It is too late to create the spenddown for that base period, but the next base period for 12/16 through 5/17 can be created as there are unpaid months in the base. The three month retro period would normally prohibit an HCBS end date of 11/30/16, but in this case the next available month to set the end date is 05/2017 – which is past the current come up month. Therefore, the Adjusted HCBS End date can be 4 months in the past. In this case, it is 11/30/16. The ES will adjust the date on the LTC Data Details page and rerun the month of May, 2016. Then, the regular process of running the months of November – current will be necessary. The months of June through November 2016 are added to the overpayment spreadsheet. December - March may be added if the consumer does not meet the spenddown.

7) REVIEW DATE – MEDICALLY NEEY CASES

If possible, the annual review date is shortened to match the end of a base period. If a Medically Needy Base period is established following LTC, the review date is adjusted to the end of the base period. If the review date is scheduled to occur during the middle of the first base, it is adjusted following the next review.

Staff must note processing instructions in KDHE Policy Memo 2016-02-01 regarding processing Reviews. Note that the full HCBS termination process will be completed regardless of any reviews issues; however, final disposition of the case is dependent upon the status of the review, as indicated in the memo.

8) PROCESS

It is important to remind staff of the criticality of both the date on the LTC Data Details screen as well as the importance of running EDBC for the correct months. The Golden Rules for LTC case processing: Always Run EDBC in the Month of the LTC Change. And, for cases where the Adjusted HCBS End Date applied, the adjusted date is viewed as the month of the LTC change.

Detailed processing instructions for HCBS terminations are included in the **Guide to Processing HCBS Terminations**. The original Policy Memo provided special processing instructions for cases

where the HCBS recipient died or entered a facility. Those processes are also included in this guide.

9) CONTRACTOR VS STATE ACTION

Although a long term care adjustment does not specifically require State authorization, the resulting changes may. The following rules apply when processing these cases:

- The Contractor can authorize a change from one type of Long Term Care to another if eligibility does not change. For example: PACE to HCBS, HCBS to NF
- The Contractor can authorize a change in LOC/LAC that doesn't result in an eligibility category change. For example: SSI program or a Temporary stay
- The Contractor can authorize LOC terminations where a new program is not being determined. This would include situations where MSP remains open as well as situations where the consumer receives SSI or PMG while receiving LTC and these programs will remain active following the LOC termination. This is true even if coverage under the 300% group terminates as a result of the LOC action.
- The State must authorize any case where a coverage change occurs as a result of the LOC action. For example: 300% to Medically Needy or Medically Needy to 300%

Notices of Action: The Contractor is responsible for sending the NOA if they can complete the entire action (bullets 1-3 above). If the case needs to be sent to the State, the State staff are responsible for sending the notices of action. This would include both the termination and the change notice that may be necessary when an LOC change is made.

Priority Processing: When cases must be sent to the State for final determination, it is important that the action be taken immediately to ensure incorrect coverage is not allowed to continue. The contractor staff should set a task priority of 'Passive Review' to ensure the case is recognized by the State staff as priority item.

10) NOTICE OF ACTION

The eligibility worker is required to send a notice of action informing the consumer of the change in eligibility based on the LOC change. The HCBS entity has already provided the recipient with notice regarding the HCBS functional change, and the KEES notice does not address the actual HCBS services termination. Any fair hearing request based on this notice is only made for the eligibility adjustment based on the termination of HCBS.

All HCBS terminations: The eligibility worker must ensure the notice sent to the consumer is correct. Whether the consumer is being discontinued for Medicaid coverage or being determined eligible for Medically Needy or a Medicare Savings Program (MSP), the following

fragment should be appended to the notice to the consumer. It has been added to the Cut and Paste spreadsheet.

This action is being taken because KanCare was notified your HCBS eligibility ended {date of termination from 3161}. This notice only pertains to your eligibility for Medicaid and does not address functional eligibility for HCBS.

A special fragment/form has been developed for use with an Adjusted HCBS End Date.

The agency had been notified that you no longer meet functional eligibility criteria for HCBS. We are closing your HCBS program effective {Date}. You will receive another notice in regard to determination for any other program for which you might qualify

Medically Needy Cases: A special Cut and Past fragments/form has been developed for use when processing cases that involve a subsequent Medically Needy base period. It is sent anytime a Medically Needy is established following a delayed HCBS end date.

11) JOURNAL

Update the Journal as appropriate. Below are some of the critical items to note in the journal entry:

- A) Include the consumer's date of death, when HCBS terminated and months EDBC were run.
- B) Include any information regarding an Adjusted HCBS End Date.
- C) Include any information regarding base periods and the spenddown – including the start and end date.
- D) Include the dates the consumer moved to IC, name of facility, whether the stay was temporary or permanent, and any Share of Cost.
- E) Include any information regarding potential overpayments.
- F) Include the following in the Journal entry.

“Worker notified by KDADS that HCBS should terminate. Entered termination date of 12/31/16 on LTC Data page. Ran EDBC for December. NOA sent.”

Then add:

“Client remains/becomes eligible for MSP; approved (QMB, LMB, E-LMB <choose one>) for January and following months. NOA sent.”

Or add:

“Client added to spouse's medical case in PB *** effective **/**/****.” Information will need Included on changes to MSP type or spenddown amount.

12) CONCLUSION

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

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